Jill Sewell

AM, FRACP, is Deputy Director, Centre for Community Child Health, Royal Children's Hospital, Melbourne, Victoria. jill.sewell@rch.org.au

School refusal

Background

School refusal occurs in 1–5% of all school children and has major social, emotional and educational implications for the child.

Objective

This article outlines the assessment and management of school refusal in general practice.

Discussion

Initial assessment includes consideration of predisposing, precipitating and perpetuating factors in the child, family and school; a thorough examination to reassure the child and parents about physical symptoms; judicious use of investigations relevant to the presenting physical symptoms; and information from the school about the child's behaviour, social functioning, academic progress, and records of attendance. Management requires collaboration between parents, school and the child to plan a school return strategy. Acknowledge the reality of the child's feelings. Provide appropriate strategies for the child to manage anxiety. Encourage parents to reduce potentially undermining doubts about successful re-entry to school and plan calm morning routines and escort to school. School strategies may include special supports such as modified curriculum, reduced homework or remedial tuition, and positively reinforcing attendance. With established longer term school refusal, referral to a multidisciplinary mental health team may be required.

School refusal occurs in 1–5% of all school children, peaking at ages 5–7 years, then 11 years and 14 years. It occurs across all socioeconomic groups, and equally among boys and girls.[1]

The term 'school refusal' refers to difficulty attending school associated with emotional distress. A common definition is 'child-motivated refusal to attend or difficulties remaining in school for the entire day'.[2] The child usually stays or returns home and doesn't attempt to conceal their nonattendance.

School refusal is often associated with overt anxiety symptoms such as fears of separation, of tests or teachers, or of transition, with depression and sometimes with oppositional behaviour. Many children say they want to go to school but just can't. Somatic symptoms are common and include headache, abdominal pain, nausea, shakiness or dizziness. Symptoms present in the morning may disappear if the child stays at home.[3] Family dysfunction may contribute, eg. high dependency, isolation, conflict and rigid roles.[4]

In contrast, children who truant are usually not anxious, conceal their truancy from parents, lack interest in school work, do not conform to the school's codes of conduct, and often engage in delinquent behaviour. These children tend to be older.[5]

School refusal usually starts gradually with vague complaints and reluctance to attend, progressing to total refusal to go or to remain in school.[6]

Children with vague physical complaints or reluctance to attend school without actual school refusal may also include those who dislike school for relevant reasons, eg. delayed social or communication skills, learning difficulties, bullying, or a poor relationship with a teacher. They will often have associated behaviour problems. These children tend to have better and worse days, and can be helped by recognition of their very real experiences of difficulty, support to improve social skills, language or learning difficulties, and by parents working in partnership with the school to understand the issues, plan appropriate support and monitor progress.

School refusal is not a diagnosis in itself, and is heterogeneous and multifactorial.[6] It is useful to think about three clinical groups,

with additional risk factors including learning difficulties and family dysfunction:

- separation – anxious school refusers, often younger
- anxious – depressed school refusers, often older
- phobic school refusers – often older.

Case study

Lam, aged 12 years, is the youngest of five daughters in a Vietnamese origin family. She has pretended to be a boy since a young age, dressing in boyish clothes, playing games with boys and refusing to conform to the expected family gender roles. She has complained of headaches and has not attended school for 3 years, saying that learning gives her headaches. She is listless and inactive, doing very little most days. The family has not sought help until now.

Lam fits into the group of anxious-depressed school refusers. There are complex family dynamics. She has missed out on the past 2 years of primary school and transition to secondary school. The chances of a successful reintegration to school are low and will require the use of extensive resources.

School refusal has very significant consequences. Short term outcomes include:

- poor academic performance
- family difficulties
- worsening peer relationships.

Longer term consequences include:

- academic underachievement
- employment difficulties
- increased risk of psychiatric illness.[3]

A considerable percentage of early school refusal situations will improve spontaneously or with consistent and firm parental input. Longer periods of refusal (>2 years), occurrence in adolescence, association with depression, and lower IQ are associated with a poor prognosis, which will also be affected by any serious underlying mental health disorder.[7]

Assessment

Knowledge of family function is important, as is understanding of the family's reactions to the school refusal. Initial assessment in general practice should include:

- consideration of predisposing, precipitating and perpetuating factors in the child, family and school, including an understanding of the child's emotional thinking such as:
  - fear of loss of parent
  - needing to protect a parent
  - excessive fear of situations within the school such as bullying, tests, change of teacher
- a thorough examination to reassure the child and parents about physical symptoms
- judicious use of investigations relevant to the presenting physical symptoms to help allay concerns. It is not appropriate to order more and more investigations for ill defined symptoms as this may reinforce the family's anxiety about organic illness
- information from the school about the child's behaviour, social functioning, academic progress and records of attendance. A diary of attendance and associated events, triggers and activities can be very helpful in recognising patterns in behaviours and emotions
- standardised parent and teacher behaviour checklists and mental health scales to help delineate problems and compare severity of behaviours at home and at school.

Management

A school return strategy should be introduced immediately if the period of refusal has been brief, or can be introduced gradually if there has been a longer refusal period. This will minimise continuing problems of missed work, social isolation, low self esteem and avoidance behaviours.

Engage the child by acknowledging the reality of feelings, working together to plan school return and dealing with anxieties through problem solving, relaxation training, breathing retraining, and social skills training.[8]

Work with parents to reduce potentially undermining doubts about successful re-entry to school. Plan calm morning routines, clear instructions, escort to school and, if necessary, allow the child to stay in contact with parents by phone (see *Resources*).

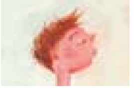
Work with the school to ensure clear understanding of the problem, arrange special supports such as modified curriculum, reduced homework or remedial tuition as required, and encourage reinforcers such as access to the garden, special lunch time activities, privileges and rewards.

Monitor regularly to review mental health symptoms and reinforce strategies.

Encouraging both parents and the school to work together to recognise early concerns, think through associated factors and put supportive management plans in place within the scope of the school and home settings, may help differentiate reluctance about school from early school refusal, as well as impede progression of school refusal. Using as many supports as possible to keep the child at school is very helpful.

Paediatric referral may be useful for more detailed assessment and management of the underlying and associated issues.

With established, longer term school refusal, referral to a multidisciplinary mental health team may be required. Treatment principles include early return to school with supportive parental involvement, teacher guidance regarding support for the child in school, and individually tailored treatment plans according to the underlying psychological basis of the school refusal. This may include behaviour management, child therapy, cognitive behavioural therapy, rarely pharmacological treatment, and more rarely, admission to hospital. Regular monitoring of progress and signs of relapse is essential.[3]



School refusal is a not uncommon problem and has major social, emotional, and educational implications for the child. Associated psychiatric disorders of anxiety and depression are common and may progress to adulthood. Assessment and management requires collaboration between parents, school personnel and the child. Early recognition and management may alleviate the distress felt by the child, the family and the school, and minimise the long term consequences, including the potential legal problems of nonattendance at school.

Resources

- The Government of South Australia Children, Youth and Women's Health Service Parenting and Child Health website includes a section on school refusal and truancy: www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=114&np=141&id=1698 and child friendly information ('When you don't want to go to school'): www.cyh.com/HealthTopics/HealthTopicDetailsKids.aspx?p=335&np=290&id=2504)
- The Raising Children Network Australian Parenting website includes a section on school morning routines: www.raisingchildren.net.au/articles/school_morning_routines.html/context/591
- The Monash University School Refusal Program is a multidisciplinary program for children aged 11–15 years: www.med.monash.edu.au/spppm/research/devpsych/srp.htmlp.

Conflict of interest: none declared.

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AFP CORRESPONDENCE afp@racgp.org.au